HIV/AIDS Education Project

2002 Iowa

School Health Education Profile

Prepared for:
Iowa Department of Education
Bureau of Instructional Services

Author:
James R. Veale, Ph.D.

February 2003

State of Iowa
Department of Education
Grimes State Office Building
Des Moines, Iowa
50319-0146

State Board of Education

Gene E. Vincent, President, Carroll
Sally J. Frudden, Charles City
Jim Billings, Spirit Lake
Charles C. Edwards, Jr., Des Moines
Sister Jude Fitzpatrick, Davenport
Gregory D. McClain, Cedar Falls
Mary Jean Montgomery, Spencer
Don Roby, Decorah
Kay Wagner, Bettendorf

Administration

Ted Stilwill, Director and Executive Officer
of the State Board of Education
Gail M. Sullivan, Chief of Staff

Bureau of Instructional Services

James Reese, Acting Chief
Sara A. Peterson, R.N., M.A., HIV/AIDS Project Director

Table of Contents

List of Tables

List of Figures

I. Introduction

The Iowa Department of Education HIV/AIDS Education Program, through a cooperative agreement with the Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention (CDC), provides assistance to schools and other youth service agencies to strengthen comprehensive school health education to prevent human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs), and to promote healthy behaviors and attitudes. Program requirements include the monitoring (at least every two years) of the number and percentage of schools that provide education to prevent health risk behaviors as part of a comprehensive school health program.

2002 Iowa SHEP: Instruments, Samples, and Reporting

The School Health Education Profile includes two questionnaires, one for school principals and one for lead health education teachers. (The questionnaires are presented in the Appendix.) The principal's questionnaire was used to provide data on school health education from an administrative perspective; the health education teacher's questionnaire provided data on school health education from an instructional standpoint. *The overall results are presented for the entire sample when the percentages are more or less homogeneous; otherwise, results are presented for (1) middle school, (2) junior/senior high school, and (3) senior high school, defined in Table 1 below.*

Table 1: Definitions of grade categories

Grade Category	Low Grade Criterion	High Grade Criterion
Middle school	-[a]	9 or lower
Junior/senior high school	8 or lower	10 or higher
Senior high school	9 or higher	10 or higher

[a] The "-" indicates no single low grade criterion was used for this grade category. However, middle schools traditionally serve grades 6 through 8 (or sometimes 9).

The questionnaires were developed by the DASH/CDC in collaboration with representatives of 75 state, local, and territorial departments of education. They were mailed to 347 secondary schools containing any of the grades 6 through 12 in Iowa during the spring of 2002. Useable survey data were obtained from 263 principals and 262 teachers.

The data are reported in summarized form. For a more detailed summary of the data, see the document *2002 School Health Education Profile Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2002). In addition to detailed tables with point and interval estimates, this report includes overhead transparencies with graphics for use in presentations. Additional transparencies will be developed for presenting the Iowa SHEP results as needed. An administrative summary is also available for more general dissemination. This document will contain the basic information regarding methodology and highlights of the results. Finally, both reports will be posted on the Iowa Department of Education Web site (**www.state.ia.us/educate**) in portable document format for electronic access.

Overview: Comprehensive School Health Education in Iowa

Effective comprehensive school health education programs focus on reducing behaviors that place youth at risk for serious health problems. This includes reducing sexual behaviors that lead to HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancies.

Other risky behaviors include tobacco use, alcohol and other drug use, improper nutrition, sedentary lifestyles, intentional and unintentional injuries, and violent activity.

The CDC's definition of a comprehensive school health education program includes the following:

- a documented, planned, sequential program of health education for students in grades K through 12;
- a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., HIV infection, drug abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages;
- activities to help young people develop the skills they will need to avoid: (a) behaviors that result in intentional and unintentional injuries; (b) drug and alcohol abuse; (c) tobacco use; (d) sexual behaviors that result in HIV infection, other STDs, and unintended pregnancies; (e) imprudent dietary patterns; and (f) inadequate physical activity;
- instruction provided for a prescribed amount of time at each grade level;
- management and coordination in each school by an education professional trained to implement the program;
- instruction from teachers who have been trained to the subject;
- involvement of parents, health professionals, and other concerned community members;
- periodic evaluation, updating, and improvement.

HIV prevention education is an important component of a comprehensive school health education program. The above definition distinguishes between (1) skills-based HIV education and comprehensive school health education and (2) HIV/AIDS awareness presentations and non-comprehensive health courses. In Iowa, an HIV policy evaluation provided direction for both policymaking process and content, including HIV education policy, addressing the needs of persons infected with HIV, and infection control procedures (Veale, 1994). More recently, needs assessments were conducted with elementary and secondary schools to determine the training and educational needs for Iowa teachers and students in HIV prevention (Veale, 2000, 2001b, and 2002b).

Regarding health education needs assessment from the student's perspective, the 2003 Iowa Youth Risk Behavior Survey is currently being conducted. It is being administered to a sample of high schools in Iowa (including alternative schools) to assess the level of involvement in risky behaviors for students in these schools. Assuming sufficient response rates for weighting the data, we will be able to make statements concerning the level of such behavior among all high school students in Iowa in 2003. The YRBS provides an important complement to the SHEP in that it provides *student* input regarding their health and risk thereto.

II. Methodology

The 2002 School Health Education Profile (SHEP) consisted of two questionnaires—one for school principals and the other for lead health education teachers (LHETs). The survey for principals consisted of questions about health and HIV education from an administrative perspective, while the survey for LHETs examined health and HIV education from an instructional standpoint. The surveys were developed cooperatively by the CDC and 75 agencies including state departments of education, as well as local and territorial education units in the United States to monitor the current status of school health education, including education to prevent HIV infection, STDs, and other important health problems that occur at the middle, junior high, and senior high school levels. The 2002 School Health Education Profile consisted of 41 questions for the school principals and 21 questions for the lead health education teachers. The rationale for the questions included in the 2002 SHEP is presented in the supplementary document *2002 School Health Education Profile Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2002). Significant changes and additions were made to the 2000 SHEP, especially in the survey for the high school principals.

Sampling Procedure

Schools were selected using systematic equal probability sampling with a random start. The principal and lead health education teacher (LHET) were surveyed at each participating school. Prior to sampling, the schools were sorted by estimated enrollment in the target grades within the school grade level (e.g., middle school). This increased the likelihood of securing a sample that was representative of the population—at least with respect to estimated enrollment. This process was repeated for each targeted school grade level.

A sample size of 347 was determined from finite sampling theory for proportions, using a 5% margin of error with 95% confidence (e.g., Cochran, 1963), assuming a response rate of 75%. This represented slightly more than 50% of the number of schools (683) in the population of middle, junior/senior high, and senior high schools in Iowa. *PCSchool*, software provided by Westat, Inc., was used to select the sample of 347 from a sampling frame consisting of all 683 schools. The sample was verified by Westat, Inc.[1]

The superintendents and principals in the schools sampled were then contacted. A cover letter was sent to each, along with a copy of both the principal and LHET surveys. The principal was asked to select one teacher to complete the LHET survey in the school. This was to have been someone who was in charge of health education in the school.

One of the schools was ruled ineligible, reducing the actual sample size to 346. Usable data were received from 263 out of the 346 sampled principals from the eligible schools. This yielded a response rate for the school principal questionnaire of 76.0%. Usable data were received from 262 out of 346 sampled lead health education teachers from the eligible schools. This yielded a response rate for the LHET questionnaire of 75.7%. Although lower than the response rates of the 2000 SHEP (which were unusually high), both of these response rates were judged sufficient by the CDC for making inferences about the populations. In fact, these rates were slightly higher than the projected rates of 75%, so the sample sizes were slightly above those required for the established margin of error (5%) and level of confidence (95%).

---

[1] The following formula was used: $ME = t\,(1 - n/N)^{\frac{1}{2}}\,[pq/(n - 1)]^{\frac{1}{2}} + 1/2n$, where "ME" is the margin of error, "t" is the value of the standard normal deviate, "N" is the population (sampling frame) size, "p" is the true value of the proportion responding in a particular way to the question, and $q = 1 - p$. Here, we set ME = .05 (5%), t = 1.96, N = 683, and p = q = 0.5. The value of 260 for "n" was obtained by iteration ("trial and error"). It was conservatively estimated that the response rate would be (at least) 0.75 or 75%. Inflating the "n" by this anticipated (minimum) response rate yielded n = 260/0.75, or 347 (rounding up).

The breakdown by school grade level is presented in Table 2 (Laura Alvarez-Rojas, personal communication, February 7, 2003). These sample sizes should be considered on questions where breakdowns over school grade levels are needed. Moreover, on particular questions, the sample sizes may be even smaller due to selective nonresponse. The statistical effect of such breakdowns is wider confidence intervals. Thus, we feel that overall results using the total sample (yielding shorter confidence intervals) should be used, with specific grade level results presented only when they are of particular interest.

Table 2: Sample size breakdown by school grade level

Survey	Number in Middle School Sample	Number in Junior/Senior High Sample	Number in Senior High Sample	Total Sample Size
Principal	103 (39.2%)	49 (18.6%)	111 (42.2%)	263
LHET	102 (38.9%)	47 (17.9%)	113 (43.1%)	262
Population	282 (41.3%)	127 (18.6%)	274 (40.1%)	683

Note the excellent agreement between the percentages in the sample (for both the principal and LHET surveys) and those of the population. Chi-square goodness-of-fit tests showed no significant differences between the population and (a) the principals' sample grade level data ($P = .752$) and (b) the LHETs' sample grade level data ($P = .602$). This is further evidence of the representativeness of the sample, the generalizability of the overall results, and the appropriateness of using the overall results (combined grade levels).

Weighting the Survey Responses

A "weight" has been associated with each questionnaire to reflect the likelihood of a principal or LHET being selected, to reduce bias by compensating for differing patterns of nonresponse, and to improve precision by making school sample distributions conform to known population distributions. The weight used for estimation of population parameters is given by

$$W = W_1 \times f_1 \times f_2$$

where

W_1 = 1/(probability of school selection);

f_1 = a nonresponse adjustment factor calculated by school size (large, medium, and small) and school grade level (middle school, junior/senior high, high school);

f_2 = a poststratification adjustment factor calculated by type of locale (large central city, mid-size central city, urban fringe of large city, urban fringe of mid-size city, large town, small town, rural metropolitan statistical area (MSA), rural non-MSA) and school grade level (middle school, junior/senior high, high school).

Thereby, the data were adjusted somewhat to reflect differences in the number of population units that each case represented. This is somewhat similar to what is done, for example, in stratified sampling. A weighted mean or percentage was computed for each item on the survey. (The actual process of weighting is rather complicated and was conducted by Westat, Inc. using specialized statistical software.)

Data Analysis

The primary focus in data analysis is on the estimation of population parameters, namely the proportion of principals or lead health education teachers with the various health education

attributes assessed in the questionnaires. These analyses were conducted by Westat, Inc., a contractor for the CDC. In addition to point estimates, 95% confidence intervals were computed. These statistics were used to make inferences concerning the health education attributes of *all regular secondary public schools in Iowa having at least one of the grades 6 through 12*.

Informal tests of statistical significance using the confidence intervals for the three grade levels (middle school, junior/senior high, and senior high school) were conducted on data from a few selected survey questions to assess the differences in the results by school grade level. Confidence intervals that did not overlap provided evidence of statistically significant differences. Since these intervals were computed by taking into account the differential weighting of the responses based on the sampling scheme (and nonresponse patterns), this method was recommended over classical methods for simple random sampling such as Pearson chi-square (Mary Nixon, Westat statistician, personal communication, December 5, 1996). For example, question 2 on the principal's survey regarding whether health education is required yielded the three confidence intervals represented in Figure 1. The fact that these confidence intervals do not all overlap (senior high school interval does not overlap with either of the other two), indicated that the results for this question differed by school grade level. In others, e.g., question 38 regarding whether or not the school has a written policy for responding to violence at the school, the confidence intervals overlapped. No differences over grade levels were indicated on this question. Confidence intervals may be similarly used to assess differences between principals' and teachers' responses to the same question.[2]

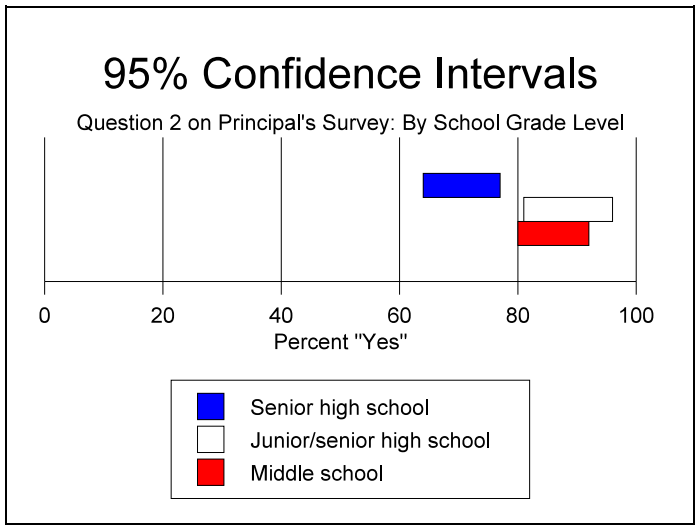

Figure 1: Non-overlapping confidence intervals on question 2 of principal's survey (evidence of statistically significant differences among school grade levels).

We always report the overall results for the total sample. Such data are meaningful even if differences exist over some of the grade levels, since the random sample was taken over the entire state. In selected questions, where significant differences are detected, the grade level results provide additional information for more specific recommendations for health education.

The point and interval estimates are presented in a supplementary report for all survey items on each of the two questionnaires using data from respondents at each of the three school grade levels, as well as the combined sample. The item question, choices, sample size ("n"), and raw counts are also presented for each item, as well as graphical representations and transparencies for use in presentations. These data summaries were produced by Westat, Inc. and are provided

[2] Differences in responses to the same questions used in surveys administered over time (e.g., the 2000 SHEP and the 2002 SHEP) are handled somewhat differently. The confidence interval approach for such differences is somewhat problematic, due to the possibility of repeated (non-independent) measurement among some of the respondents. For example, suppose "principal *x*" was selected for and responded to *both* the 2000 and 2002 SHEP, whereas "principal *y*" was selected and responded to only the 2000 SHEP. The data for principal *x* is repeated, violating the independence assumption (over years). Thus, some measurements are repeated (dependent), while others are not repeated (independent). In this report, only results where such differences were "substantial" (based on author judgement) were cited.

in the document *2002 School Health Education Profile Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2002).

Summary Methods

The data are reported here in summarized form. This includes the percentages responding "Yes" (or selecting a particular choice) for binary coded questions, and the percentages for the most frequently selected response choice(s) in questions with three or more possible choices. The percentages for middle, junior/senior high, and/or senior high school are presented for selected questions. In addition, comparisons are made between principals' and teachers' responses to items common to both surveys and with results from the 2000 SHEP for selected questions.

III. 2002 Iowa School Health Education Profile:

Results of the School Principal Survey

The overall results of the 2002 Iowa SHEP based on the school principal survey are presented below for secondary schools. Point estimates (in percent) are provided along with the number of responses on which these percentages were based. In selected questions, grade level breakdowns and/or comparisons with responses by lead health education teachers are provided if significant differences were indicated.

Eligibility Question

Question 1: Are any of the following grades taught in this school? (Grades 6-12 were given as choices.)

This question was asked to determine eligibility for the survey. There were considerable differences over grade level categories as one might expect. (For the data on this question, see the document *2002 School Health Education Profile Report: Iowa Department of Education* (Centers for Disease Control and Prevention, 2002).) Only one school was determined to be ineligible.

Required Health Education

Question 2: Is health education required for students in any of grades 6 through 12 in this school? (Mark one response.)

Based on 260 responses, it is estimated that 80% of secondary principals indicated that health education was required for students in one or more of grades 6 through 12.

There were significant differences between (1) middle school and junior/senior high school principals and (2) senior high school principals on this question ($P < .05$). The percentage responding "Yes" varied from 86% in middle schools and 88% in junior/senior high schools to 71% in senior high schools. A higher percentage of middle school and junior/senior high school principals indicated that health education was required in their schools than did senior high school principals. (Recall Figure 1 and the discussion on p. 5.)

Question 3: Is required health education taught in each of the following ways to students in grades 6 through 12 in this school? (Mark yes or no for each method.)

a. In a combined health education and physical education course

b. In a course mainly about another subject other than health education such as science, social studies, home economics, or English

Based on 198 responses, 40% of secondary principals indicated required health education was taught in a combined health education and physical education course, while 46% indicated it was taught mainly in a course about another subject (e.g., science, social studies, home economics, or English).

Required Health Education Course

Question 4: How many required health education courses do students take in grades 6 through 12? (Mark one response.)

Based on 203 school principal responses, 46% indicated students took one course, 22% indicated students took two courses, 13% said students took three courses, and 9% indicated four or more courses were taken.

Question 5: Is a required health education course taught in each of the following grades in this school? (Mark yes, no, or not applicable for each grade.)

Based on between 85 and 119 responses, the overall percentage responding in the affirmative ranged from 69% in grade 7 to only 36% in Grade 11 and 32% in Grade 12.

Question 6: During this school year, about what percent of students in grades 6 through 12 were exempted or excused from any part of a required health education course by parental request? (Mark one response.)

Based on 184 responses, 64% indicated less than 1% were exempted/excused by parental request. This was followed by 28% who indicated that students could not be exempted or excused by parental request in their schools.

Health Education Coordination

Question 7: Who coordinates health education in this school? (Mark one response.)

Overall, based on 255 principals responding to this question, 45% indicated the health education teacher coordinated health education in their school, followed by the district health education or curriculum coordinator with 20%.

Question 8: Does this school or school district have a school health committee or advisory group that develops policies, coordinates activities, or seeks student and family involvement in programs that address health issues? (Mark one response.)

Based on 259 responses, 39% of principals responded in the affirmative to this question.

Physical Education and Physical Activity Programs

Question 9: Is physical education required for students in any of grades 6 through 12 in this school? (Mark one response.)

Based on 262 responses, 99% of principals responded in the affirmative to this question.

Question 10: Can students be exempted from taking required physical education for any of the following reasons? (Mark yes or no for each reason.)

a. Enrollment in other courses (i.e., math or science)

b. Participation in school sports

c. Participation in other school activities (i.e., ROTC, marching band, chorus, or cheerleading)

d. Participation in community sports activities

Based on 255 responses, 41% indicated students may be exempted from physical education by their enrollment in other courses, while 21% indicated students may be exempted from physical education by their participation in school sports. (Fewer than 10% indicated such exemptions may be obtained for participation in other school or community activities.)

Question 11: If students fail required physical education, are they required to repeat it? (Mark one response.)

Based on 253 responses, 60% responded in the affirmative to this question.

Question 12: Are faculty and staff at this school allowed to use physical activity, such as laps or push-ups, to punish students for bad behavior in physical education? (Mark one response.)

Based on 255 responses, 20% responded in the affirmative to this question.

Question 13: Are faculty and staff at this school allowed to make students miss all or part of physical education as punishment for bad behavior in another class? (Mark one response.)

Based on 260 responses, 6% responded in the affirmative to this question.

Question 14: Is a newly hired physical education teacher or specialist required to be certified, licensed, or endorsed by the state in physical education? (Mark one response.)

Based on 260 responses, 99% responded in the affirmative to this question.

Question 15: Does this school offer students opportunities to participate in intramural activities or physical activity clubs? (Mark one response.)

Based on 262 responses, 49% responded in the affirmative to this question.

Question 16: Does this school provide transportation home for students who participate in after-school intramural activities or physical activity clubs? (Mark one response.)

Based on 259 responses, most (43%) responded that no such activities were offered in their school. Only 18% responded in the affirmative to this question.

Question 17: Outside of school hours or when school is not in session, do children or adolescents use any of this school's activity or athletic facilities for community-sponsored sports teams or physical activity programs? (Mark one response.)

Based on 262 responses, 95% responded in the affirmative to this question.

Tobacco Prevention Policies

Question 18: Has this school adopted a policy prohibiting tobacco use? (Mark one response.)

Based on 259 responses to this question, nearly all (99%) of the secondary school principals responded affirmatively to this question.

Question 19: Does the tobacco prevention policy specifically prohibit use of each type of tobacco for each of the following groups? (Mark yes or no for each type of tobacco for each group.)

a. Cigarettes

b. Smokeless tobacco (i.e., chewing tobacco, snuff, or dip)

c. Cigars

d. Pipes

The groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on about 250 responses, the percent affirming that their policies prohibited the various types of tobacco listed was 94-96% for students, 70-73% for faculty/staff, and 65-71% for school visitors.

Question 20: Does the tobacco prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups? (Mark yes or no for each time for each group.)

a. During school hours

b. During non-school hours

As in the previous question, the groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on about 250 responses, the percent indicating their policies prohibited tobacco use for students was 100% during school hours and 92% during non-school hours; for faculty/staff, 77% during school hours and 56% during non-school hours; for visitors, 75% during school hours and 53% during non-school hours.

Question 21: Does that policy specifically prohibit tobacco use in each of the following locations for each of the following groups? (Mark yes or no for each location for each group.)

Location

a. In school buildings

b. On school grounds

c. In school buses or other vehicles used to transport students

d. At off-campus, school-sponsored events

As in the previous questions, the groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on about 250 responses regarding the various locations, nearly all principals (99-100%) responded that smoking was specifically prohibited therein for students. Based on about 250 responses regarding the locations "In school buildings" and "In school buses ... students," again nearly all (97%) affirmed that smoking was specifically prohibited in those areas for faculty/staff, while for locations "On school grounds" and "At off-campus, school-sponsored events" 63% indicated that smoking was specifically prohibited for faculty/staff. Again based on about 250 responses regarding the "In school buildings" and "In school buses ...students," most (96% and 91%, respectively) indicated that smoking was specifically prohibited for visitors, while for locations "On school grounds" and "At off-campus, school-sponsored events" just 51% and 42% (respectively) indicated that smoking was specifically prohibited for visitors.

Question 22: Does your school have procedures to inform each of the following groups about the tobacco prevention policy that prohibits their use of tobacco? (Mark yes, no, or not applicable for each group.)

As in the previous questions, the groups included (1) students, (2) faculty/staff, and (3) visitors.

Based on about 250 responses, 98% of principals indicated their schools had procedures to inform students about the tobacco prevention policy prohibiting use of tobacco, 90% indicated they had procedures to inform faculty/staff about the tobacco prevention policy prohibiting use of tobacco, and 67% indicated they had procedures to inform faculty/staff about the tobacco prevention policy prohibiting use of tobacco.

Question 23: Does your school have procedures to inform parents about the policy that prohibits tobacco use by students? (Mark one response.)

Based on 253 responses, 98% of the principals responded in the affirmative on this question.

Question 24: Does your school designate an individual who has primary responsibility for seeing that the tobacco use prevention policy is enforced? (Mark one response.)

Based on 253 responses, 62% of the principals responded in the affirmative on this question.

Question 25: When students are caught smoking cigarettes, how often are each of the following actions taken? (Mark one response for each action.)

Action

a. Parents or guardians are informed

Based on the 252 principals responding to this question regarding this action, 99% indicated parents or guardians were always or almost always informed.

b. Referred to a school counselor

Based on the 249 principals responding to this question regarding this action, 50% indicated students were sometimes referred to a counselor and 29% indicated they were always or almost always so referred.

c. Referred to a school administrator

Based on the 252 principals responding to this question regarding this action, 99% indicated students were always or almost always so referred.

d. Encouraged, but not required to participate in an assistance, education, or cessation program

Based on the 248 principals responding to this question regarding this action, 43% indicated students were sometimes encouraged to participate in such a program, while 25% indicated they were always or almost always so encouraged.

e. Required to participate in an assistance, education, or cessation program

Based on the 245 principals responding to this question regarding this action, 35% indicated students were never required to participate in such a program and 27% indicated they were rarely so required, while 31% indicated they were sometimes required to do so.

f. Referred to legal authorities

Based on the 248 principals responding to this question regarding this action, 41% indicated students were always or almost always referred to legal authorities and 32% indicated they were sometimes so referred.

g. Placed in detention

Based on the 245 principals responding to this question regarding this action, 57% indicated students were never or rarely placed in detention (if caught smoking cigarettes), while 24% indicated they were sometimes detained and 19% indicated they were always or almost always detained.

h. Given in-school suspension

Based on the 247 principals responding to this question regarding this action, 36% indicated students were always or almost always given in-school suspension and 32% indicated they were sometimes given such suspension.

i. Suspended from school

Based on the 250 principals responding to this question regarding this action, 32% indicated students were always or almost always suspended from school and 33% indicated they were sometimes suspended therefrom.

Question 26: Does your school provide referrals to tobacco cessation programs for each of the following groups? (Mark yes or no for each group.)

The groups were (a) faculty and staff and (b) students.

Based on the 256 principals responding to this question, 20% indicated that faculty and staff would be referred to tobacco cessation programs, while 53% indicated that students would be so referred (if caught using tobacco).

Question 27: Is tobacco advertising prohibited in each of the following locations? (Mark yes or no for each location.)

Location:

a. In the school building

Based on 258 principals responding to this part of the question, 93% indicated tobacco advertising was prohibited in the school building.

b. On school grounds including on the outside of the building, on playing fields, or other areas of the campus

Based on 258 principals responding to this part of the question, 91% indicated tobacco advertising was prohibited on the school grounds.

c. On school buses or other vehicles used to transport students

Based on 257 principals responding to this part of the question, 91% indicated tobacco advertising was prohibited on school buses or other student transportation vehicles.

d. In school publications (e.g., newsletters, newspapers, web sites, or other school publications)

Based on 258 principals responding to this part of the question, 92% indicated tobacco advertising was prohibited in school publications.

Question 28: Is tobacco advertising through sponsorship of school events prohibited? (Mark one response.)

Based on 257 principals responding to this question, 93% indicated tobacco advertising though sponsorship of school events was prohibited.

Question 29: Are students at your school prohibited from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it? (Mark one response.)

Based on 260 principals responding to this question, 98% indicated students were prohibited from wearing tobacco brand-name apparel or carrying such merchandise.

Question 30: Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use by students, faculty and staff, and visitors is not allowed? (Mark one response.)

Based on 260 principals responding to this question, 46% indicated their school posted signs marking a tobacco-free school zone. This was a substantial increase from the percentage of schools indicating they posted such signs in the 2000 SHEP (28%).

Nutrition-Related Policies and Practices

Question 31: How long do students usually have to eat lunch once they are seated? (Mark one response.)

a. Less than 20 minutes

b. 20 minutes or more

c. This school does not serve lunch to students

Based on 261 principals responding to this question, 38% indicated students had less than 20 minutes, while 61% said they had 20 minutes or more to eat lunch once seated.

Question 32: Does this school or district have a policy stating that fruits or vegetables will be offered at school settings such as student parties, after-school programs, staff meetings, parents' meetings, or concession stands? (Mark one response.)

Based on 261 principals responding to this question, only 6% indicated they had such a policy.

Question 33: Can student purchase snack foods or beverages from vending machines or at the school store, canteen, or snack bar? (Mark one response.)

Based on 259 principals, 90% responded in the affirmative to this question.

Question 34: Can students purchase each snack food or beverage from vending machines or at the school store, canteen, or snack bar? (Mark yes or no for each food or beverage.)

Food/Beverage

a. Chocolate candy

b. Other kinds of candy

c. Salty snacks that are *not* low in fat, such as regular potato chips

d. Salty snacks that *are* low in fat, such as pretzels, baked chips, or other low fat chips

e. Fruits or vegetables

f. Low-fat cookies, crackers, cakes, pastries, or other low-fat baked goods

g. Soft drinks, sports drinks, or fruit drinks that are not 100% juice

h. 100% fruit juice

i. Bottled water

Based on about 230 responses, about 70-75% indicated candy and salty snacks were available, 62% indicated low-fat baked goods were available, and about 90% indicated that the various types of beverages listed were available. Only 37% indicated that fruits or vegetables were available for purchase at their school.

Question 35: Can students purchase snack foods or beverages during the following times? (Mark yes or no for each time.)

Time

a. Before classes begin in the morning

b. During any school hours when meals are not being served

c. During school lunch periods

Based on about 230 principals responding to this question, the percentage indicating students could purchase snack foods/beverages was (a) 75% before classes begin in the morning, (b) 56% during any school hours when meals are not being served, and (c) 48% during school lunch periods.

Violence Prevention

Question 36: Does your school implement each of the following safety and security measures? (Mark yes or no for each measure.)

Measure

a. Require visitors to report to the main office or reception area upon arrival

Based on 262 principals responding to this part of the question, 98% indicated visitors were so required.

b. Maintain a "closed campus" where students are not allowed to leave school during the day, including during lunch

Based on 262 principals responding to this part of the question, 73% indicated a closed campus was maintained in their schools.

c. Use staff or adult volunteers to monitor school halls during and between classes

Based on 261 principals responding to this part of the question, 85% indicated they used staff or adult volunteers to monitor their school halls.

d. Routinely conduct bag, desk, or locker checks

Based on 261 principals responding to this part of the question, 40% indicated they routinely conducted such checks.

e. Prohibit students from carrying backpacks or book bags at school

Based on 262 principals responding to this part of the question, 33% indicated backpacks or book bags were prohibited in their schools.

f. Require students to wear school uniforms

Just one of the 262 principals (0%) responding to this part of the question indicated their students were required to wear school uniforms.

g. Require students to wear identification badges

Just one of the 262 principals (0%) responding to this part of the question indicated their students were required to wear identification badges.

h. Use metal detectors

Just two of the 262 principals (1%) responding to this part of the question indicated metal detectors were used in their schools.

i. Have uniformed police, undercover police, or security guards during the regular school day

Based on 262 principals responding to this part of the question, 14% indicated they had uniformed or undercover police or security guards during the regular school day.

Question 37: Does your school have or participate in each of the following programs? (Mark yes or no for each program.)

Program

a. A peer mediation program

Based on 262 principals responding to this part of the question, 38% indicated they had or participated in a peer mediation program.

b. A safe-passage to school program

Based on 261 principals responding to this part of the question, just 4% indicated they had or participated in a safe-passage to school program.

c. A program to prevent gang violence

Based on 260 principals responding to this part of the question, 12% indicated they had or participated in a program to prevent gang violence.

d. A program to prevent bullying

Based on 260 principals responding to this part of the question, 44% indicated they had or participated in a program to prevent bullying.

Question 38: Does your school have a written plan for responding to violence at the school? (Mark one response.)

Based on 262 principals responding to this question, 96% indicated they had a written plan for responding to violence.

Asthma Management Activities

Question 39: Does your school implement each of the following school-based asthma management activities? (Mark yes or no for each activity.)

Activity

a. Provide a full-time registered nurse, all day every day

Based on 263 principals responding to this part of the question, 41% indicated they provided this service.

b. Identify and track all students with asthma

Based on 263 principals responding to this part of the question, 86% indicated they identified and tracked such students.

c. Obtain and use an Asthma Action Plan (or Individualized Health Plan) for all students with asthma

Based on 259 principals responding to this part of the question, 57% indicated they utilized such a plan.

d. Assure immediate access to medications as prescribed by a physician and approved by parents (allow students to self-carry inhalers)

Based on 262 principals responding to this part of the question, 94% indicated they assured immediate access to such medications.

e. Provide intensive case management for students with asthma who are absent 10 days or more per year

Based on 254 principals responding to this part of the question, 31% indicated they provided such case management services.

f. Educate school staff about asthma

Based on 260 principals responding to this part of the question, 60% indicated they educated staff about asthma.

g. Educate students with asthma about asthma management

Based on 259 principals responding to this part of the question, 52% indicated they educated students with asthma about asthma management.

h. Teach asthma awareness to all students in at least one grade

Based on 251 principals responding to this part of the question, 23% indicated they taught asthma awareness to all students in at least one grade.

i. Encourage full participation in physical education and physical activity when students with asthma are doing well

Based on 262 principals responding to this part of the question, 99% indicated they encouraged full participation in such situations.

j. Provide modified physical education and physical activities as indicated by the student's Asthma Action Plan

Based on 259 principals responding to this part of the question, 85% indicated they provided modified physical education/activities suggested in the student's Asthma Action Plan.

HIV Infection Policies

Question 40: Has this school adopted a written policy that protects the rights of students and/or staff with HIV infection or AIDS?

Based on 256 principals responding to this question, 65% indicated they had a written policy that protects the rights of students or staff living with HIV or AIDS. This percentage was substantially higher than the percentage of principals so indicating in the 2000 SHEP (49%).

Question 41: Does that policy address each of the following issues for students and/or staff with HIV infection or AIDS? (Mark yes or no for each issue.)

Issue

a. Attendance of students with HIV infection or AIDS

Based on 162 principals responding to this part of the question, 89% indicated they addressed the issue of attendance of these students in the written policy.

b. Procedures to protect HIV-infected students and staff from discrimination

Based on 162 principals responding to this part of the question, 92% indicated they addressed the issue of procedures to protect these students and staff from discrimination in the written policy.

c. Maintaining confidentiality of HIV-infected students and staff

Based on 163 principals responding to this part of the question, 95% indicated they addressed the issue of maintaining confidentiality of these students and staff in the written policy.

d. Worksite safety (i.e., universal precautions for all school staff)

Based on 162 principals responding to this part of the question, 98% indicated they addressed the issue of worksite safety in the written policy.

e. Confidential counseling for HIV-infected students

Based on 161 principals responding to this part of the question, 68% indicated they addressed the issue of confidential counseling for these students in the written policy.

f. Communication of the policy to students, school staff, and parents

Based on 162 principals responding to this part of the question, 86% indicated they addressed the issue of communication of the policy to students, school staff, and parents.

g. Adequate training about HIV infection for school staff

Based on 163 principals responding to this part of the question, 89% indicated they addressed the issue of training about HIV infection for school staff in the written policy.

h. Procedures for implementing the policy

Based on 162 principals responding to this part of the question, 92% indicated they addressed the issue of procedures for implementing the written policy.

[Note: The percentages in the above question were based on a smaller number than the previous ones. This is because only those who answered question 40 in the affirmative (168) were to respond to question 41. (A few of these chose not to respond to certain parts of question 41.)]

IV. 2002 Iowa School Health Education Profile:

Results of the Lead Health Education Teacher Survey

The results of the 2002 Iowa SHEP based on the lead health education teacher survey are presented below. Point estimates (in percent) are provided along with the number of responses on which these percentages were based. In selected questions, grade level breakdowns and/or comparisons with responses by principals are provided if significant differences were indicated.

Required Health Education Courses

Question 1: Is a health education course required for students in any of grades 6 through 12 in this school? (Mark one response.)

Based on 255 responses to this question, it was estimated that 71% of lead health education teachers (LHETs) indicated that health education was required for students in one or more of grades 6 through 12. Note that this compares with 80% of principals who so indicated. This difference was statistically significant ($P < .05$). Proportionately fewer teachers than principals think that there is a required health education course in grades 6 through 12 in their school. Moreover, there were no grade level differences on this question ($P > .05$).

> [Note: Teachers responding "no" to question 1 were instructed to proceed to question 11. Thus, the percentages in questions 2-10 were based on fewer responses. Moreover, not all of those responding affirmatively to question 1 (181) chose to respond to these questions.]

Question 2: Are teachers in this school required to use each of the following materials in a required health education course for student in grades 6 through 12? (Mark yes or no for each type of material.)

Materials

a. The National Health Education Standards

Based on 165 responses to this part of the question, 36% of LHETs indicated that the National Health Education Standards were required to be used in required health education courses.

b. Your state's curriculum, set of guidelines, or framework

Based on 164 responses to this part of the question, 53% of LHETs indicated that their state's materials were required to be used in required health education courses.

c. Your district's curriculum, set of guidelines, or framework

Based on 171 responses to this part of the question, 84% of LHETs indicated that their district's materials were required to be used in required health education courses.

d. Your school's curriculum, set of guidelines, or framework

Based on 166 responses to this part of the question, 83% of LHETs indicated that their school's materials were required to be used in required health education courses.

e. Any materials from health organizations, such as the American Red Cross or the American Cancer Society

Based on 163 responses to this part of the question, 27% of LHETs indicated that materials from health organizations were required to be used in required health education courses.

f. A commercially-developed student textbook

Based on 166 responses to this part of the question, 46% of LHETs indicated that a commercially-developed textbook was required to be used in required health education courses.

g. A commercially-developed teacher's guide

Based on 164 responses to this part of the question, 40% of LHETs indicated that a commercially-developed teacher's guide was required to be used in required health education courses.

Question 3: During this school year, have teachers in this school tried to increase student knowledge on each of the following topics in a required health education course in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. Accident or injury prevention

Based on 166 responses to this part of the question, 84% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of accident or injury prevention.

b. Alcohol or other drug use prevention

Based on 171 responses to this part of the question, 99% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of alcohol or other drug use prevention.

c. Consumer health

Based on 170 responses to this part of the question, 80% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of consumer health.

d. CPR (Cardiopulmonary resuscitation)

Based on 166 responses to this part of the question, 63% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of CPR.

e. Death and dying

Based on 170 responses to this part of the question, 58% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of death and dying.

f. Dental and oral health

Based on 168 responses to this part of the question, 68% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of dental and oral health.

g. Emotional and mental health

Based on 171 responses to this part of the question, 92% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of emotional and mental health.

h. Environmental health

Based on 168 responses to this part of the question, 74% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of environmental health.

i. First aid

Based on 167 responses to this part of the question, 76% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of first aid.

j. Growth and development

Based on 169 responses to this part of the question, 91% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of growth and development.

k. HIV (Human Immunodeficiency virus) prevention

Based on 169 responses to this part of the question, 98% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of HIV prevention.

l. Human sexuality

Based on 171 responses to this part of the question, 92% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of human sexuality.

m. Immunization and vaccinations

Based on 166 responses to this part of the question, 65% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of immunization and vaccinations.

n. Nutrition and dietary behavior

Based on 164 responses to this part of the question, 98% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of nutrition and dietary behavior.

o. Personal hygiene

Based on 167 responses to this part of the question, 86% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of personal hygiene.

p. Physical activity and fitness

Based on 163 responses to this part of the question, 98% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of physical activity and fitness.

q. Pregnancy prevention

Based on 169 responses to this part of the question, 88% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of pregnancy prevention.

r. STD (sexually transmitted disease) prevention

Based on 171 responses to this part of the question, 95% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of STD prevention.

s. Suicide prevention

Based on 168 responses to this part of the question, 67% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of suicide prevention.

t. Sun safety or skin cancer prevention

Based on 167 responses to this part of the question, 77% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of sun safety or skin cancer prevention.

u. Tobacco use prevention

Based on 167 responses to this part of the question, 98% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of tobacco use prevention.

v. Violence prevention (such as bullying, fighting, or homicide)

Based on 169 responses to this part of the question, 79% of LHETs indicated that teachers in their school tried to increase student knowledge in the area of violence prevention.

Question 4: During this school year, have teachers in this school tried to improve each of the following student skills in a required health education course in any of grades 6 through 12? (Mark yes or no for each skill.)

Skill

a. Accessing valid health information, products, and services

Based on 168 responses to this part of the question, 81% of LHETs indicated that they tried to improve student skills in accessing valid health information, products, and services, in required health education courses.

b. Advocating for personal, family, and community health

Based on 168 responses to this part of the question, 82% of LHETs indicated that they tried to improve student skills in advocating for personal, family, and community health, in required health education courses.

c. Analysis of media messages

Based on 169 responses to this part of the question, 80% of LHETs indicated that they tried to improve student skills in analyzing media messages, in required health education courses.

d. Communication

Based on 168 responses to this part of the question, 90% of LHETs indicated that they tried to improve student communication skills, in required health education courses.

e. Decision making

Based on 170 responses to this part of the question, 96% of LHETs indicated that they tried to improve student decision making skills, in required health education courses.

f. Goal setting

Based on 169 responses to this part of the question, 90% of LHETs indicated that they tried to improve student goal setting skills, in required health education courses.

g. Conflict resolution

Based on 168 responses to this part of the question, 78% of LHETs indicated that they tried to improve student conflict resolution skills, in required health education courses.

h. Resisting peer pressure for unhealthy behaviors (i.e., refusal skills)

Based on 169 responses to this part of the question, 95% of LHETs indicated that they tried to improve student refusal skills, in required health education courses.

i. Stress management

Based on 169 responses to this part of the question, 86% of LHETs indicated that they tried to improve student stress management skills, in required health education courses.

Question 5: During this school year, have teachers in this school used each of the following teaching methods in a required health education course in any of grades 6 through 12? (Mark yes or no for each teaching method.)

Teaching method

a. Group discussions

Based on 167 responses to this part of the question, 99% of LHETs indicated that they used group discussions in required health education courses.

b. Cooperative group activities

Based on 168 responses to this part of the question, 95% of LHETs indicated that they used cooperative group activities in required health education courses.

c. Role play, simulations, or practice

Based on 167 responses to this part of the question, 79% of LHETs indicated that they used role play, simulations, or practice in required health education courses.

d. Language, performing, or visual arts

Based on 164 responses to this part of the question, 62% of LHETs indicated that they used language, performing, or visual arts in required health education courses.

e. Pledges or contracts for behavior change

Based on 164 responses to this part of the question, 39% of LHETs indicated that they used pledges or contracts for behavior change in required health education courses.

f. Adult guest speakers

Based on 166 responses to this part of the question, 83% of LHETs indicated that they used adult guest speakers in required health education courses.

g. Peer educators

Based on 166 responses to this part of the question, 51% of LHETs indicated that they used peer educators in required health education courses.

h. The Internet

Based on 167 responses to this part of the question, 84% of LHETs indicated that they used the Internet in required health education courses.

i. Computer-assisted instruction

Based on 165 responses to this part of the question, 53% of LHETs indicated that they used computer-assisted instruction in required health education courses.

Question 6: During this school year, have teachers in this school asked students to participate in each of the following activities as part of a required health education course in any of grades 6 through 12? (Mark yes or no for each activity.)

Activity

a. Perform volunteer work at a hospital, a local health department, or any other community organization that addresses health issues

Based on 163 responses to this part of the question, 13% of LHETs indicated that they asked students to perform volunteer work in an organization that addresses health issues as part of a required health education course.

b. Participate in or attend a school or community health fair

Based on 163 responses to this part of the question, 15% of LHETs indicated that they asked students to participate in or attend a school or community health fair as part of a required health education course.

c. Gather information about health services that are available in the community

Based on 163 responses to this part of the question, 51% of LHETs indicated that they asked students to gather information about health services that are available in the community as part of a required health education course.

d. Visit a store to compare prices of health products

Based on 163 responses to this part of the question, 25% of LHETs indicated that they had students visit a store to compare prices of health products as part of a required health education course.

e. Identify potential injury sites at school, home, or in the community

Based on 164 responses to this part of the question, 46% of LHETs indicated that they asked students to identify potential injury sites at school, home, or in the community as part of a required health education course.

f. Identify and analyze advertising in the community designed to influence health behaviors or health risk behaviors

Based on 164 responses to this part of the question, 62% of LHETs indicated that they asked students to identify and analyze advertising in the community designed to influence health behaviors or health risk behaviors as part of a required health education course.

g. Advocate for a health-related issue

Based on 162 responses to this part of the question, 42% of LHETs indicated that they asked students to advocate for a health-related issue as part of a required health education course.

h. Complete homework assignments with family members

Based on 164 responses to this part of the question, 77% of LHETs indicated that they had students complete homework assignments with family members as part of a required health education course.

Question 7: During this school year, did teachers in this school teach each of the following tobacco use prevention topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. Short- and long-term health consequences of cigarette smoking (such as stained teeth, bad breath, heart disease, and cancer)

Based on 166 responses to this part of the question, 97% of LHETs indicated that they taught the short-term and long-term health consequences of cigarette smoking as part of a required health education course.

b. Benefits of *not* smoking cigarettes (including long- and short-term health benefits, social benefits, environmental benefits, and financial benefits)

Based on 166 responses to this part of the question, 96% of LHETs indicated that they taught the benefits of not smoking cigarettes as part of a required health education course.

c. Risks of cigar or pipe smoking

Based on 166 responses to this part of the question, 84% of LHETs indicated that they taught the risks of cigar or pipe smoking as part of a required health education course.

d. Short- and long-term health consequences of using smokeless tobacco

Based on 166 responses to this part of the question, 94% of LHETs indicated that they taught the short- and long-term health consequences of using smokeless tobacco as part of a required health education course.

e. Benefits of *not* using smokeless tobacco

Based on 165 responses to this part of the question, 90% of LHETs indicated that they taught the benefits of not using smokeless tobacco as part of a required health education course.

f. Addictive effects of nicotine in tobacco products

Based on 166 responses to this part of the question, 95% of LHETs indicated that they taught the addictive effects of nicotine in tobacco products as part of a required health education course.

g. How many young people use tobacco

Based on 165 responses to this part of the question, 90% of LHETs indicated that they taught how many young people use tobacco as part of a required health education course.

h. The number of illnesses and deaths related to tobacco use

Based on 165 responses to this part of the question, 91% of LHETs indicated that they taught the number of illnesses and deaths related to tobacco use as part of a required health education course.

i. Influence of families on tobacco use

Based on 164 responses to this part of the question, 89% of LHETs indicated that they taught the influence of families on tobacco use as part of a required health education course.

j. Influence of media on tobacco use

Based on 165 responses to this part of the question, 94% of LHETs indicated that they taught the influence of media on tobacco use as part of a required health education course.

k. Social or cultural influences on tobacco use

Based on 165 responses to this part of the question, 89% of LHETs indicated that they taught the social or cultural influences on tobacco use as part of a required health education course.

l. How to find valid information or services related to tobacco use prevention or cessation

Based on 165 responses to this part of the question, 62% of LHETs indicated that they taught how to find valid information or services related to tobacco use prevention/cessation as part of a required health education course.

m. Making a personal commitment not to use tobacco

Based on 164 responses to this part of the question, 65% of LHETs indicated that they taught the importance of making a personal commitment not to use tobacco as part of a required health education course.

n. How students can influence or support others to prevent tobacco use

Based on 165 responses to this part of the question, 79% of LHETs indicated that they taught how students can influence or support others to prevent tobacco use as part of a required health education course.

o. How students can influence or support others in efforts to quit using tobacco

Based on 165 responses to this part of the question, 80% of LHETs indicated that they taught how students can influence or support others in efforts to quit using tobacco as part of a required health education course.

p. How to say no to tobacco use

Based on 166 responses to this part of the question, 95% of LHETs indicated that they taught how to say no to tobacco use as part of a required health education course.

q. The health effects of environmental tobacco smoke (ETS) or second-hand smoke

Based on 165 responses to this part of the question, 95% of LHETs indicated that they taught the health effects of environmental tobacco smoke (ETS) or second-hand smoke as part of a required health education course.

Question 8: During this school year, did teachers in this school teach each of the following HIV prevention topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. Abstinence as the most effective method to avoid HIV infection

Based on 168 responses to this part of the question, 97% of LHETs indicated that they taught abstinence as the most effective method to avoid HIV infection as part of a required health education course.

b. How HIV is transmitted

Based on 168 responses to this part of the question, 97% of LHETs indicated that they taught how HIV is transmitted as part of a required health education course.

c. How HIV affects the human body

Based on 167 responses to this part of the question, 96% of LHETs indicated that they taught how HIV affects the human body as part of a required health education course.

d. How to correctly use a condom

Based on 167 responses to this part of the question, 44% of LHETs indicated that they taught how to correctly use a condom as part of a required health education course.

e. Condom efficacy, that is, how well condoms work and don't work

Based on 169 responses to this part of the question, 76% of LHETs indicated that they taught condom efficacy as part of a required health education course.

f. Influence of alcohol and other drugs on HIV-related risk behaviors

Based on 169 responses to this part of the question, 90% of LHETs indicated that they taught the influence of alcohol and other drugs on HIV-related risk behaviors as part of a required health education course.

g. Social or cultural influences on HIV-related risk behaviors

Based on 169 responses to this part of the question, 83% of LHETs indicated that they taught social or cultural influences on HIV-related risk behaviors as part of a required health education course.

h. The number of young people who get HIV

Based on 168 responses to this part of the question, 86% of LHETs indicated that they taught the number of young people who get HIV as part of a required health education course.

i. How to find valid information or services related to HIV or HIV testing

Based on 167 responses to this part of the question, 76% of LHETs indicated that they taught how to find valid information or services related to HIV or HIV testing as part of a required health education course.

j. Compassion for persons living with HIV or AIDS

Based on 169 responses to this part of the question, 80% of LHETs indicated that they taught compassion for persons living with HIV or AIDS as part of a required health education course.

Question 9: During this school year, did teachers in this school teach each of the following nutrition and dietary topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. The benefits of healthy eating

Based on 165 responses to this part of the question, 97% of LHETs indicated that they taught the benefits of healthy eating as part of a required health education course.

b. The Food Guide Pyramid

Based on 165 responses to this part of the question, 93% of LHETs indicated that they taught the Food Guide Pyramid as part of a required health education course.

c. The Dietary Guidelines for Americans

Based on 164 responses to this part of the question, 82% of LHETs indicated that they taught the Dietary Guidelines for Americans as part of a required health education course.

d. Using food labels

Based on 166 responses to this part of the question, 88% of LHETs indicated that they taught using food labels as part of a required health education course.

e. Aiming for a healthy weight (balancing food intake and physical activity)

Based on 167 responses to this part of the question, 91% of LHETs indicated that they taught aiming for a healthy weight as part of a required health education course.

f. Choosing a variety of grains daily, especially whole grains

Based on 166 responses to this part of the question, 86% of LHETs indicated that they taught choosing a variety of grains daily as part of a required health education course.

g. Choosing a variety of fruits and vegetables daily

Based on 166 responses to this part of the question, 90% of LHETs indicated that they taught choosing a variety of fruits and vegetables daily as part of a required health education course.

h. Choosing a diet low in saturated fat and cholesterol and moderate in total fat

Based on 167 responses to this part of the question, 90% of LHETs indicated that they taught choosing a diet low in saturated fat and cholesterol and moderate in total fat as part of a required health education course.

i. Moderating intake of sugars

Based on 165 responses to this part of the question, 88% of LHETs indicated that they taught moderating intake of sugars as part of a required health education course.

j. Choosing and preparing foods with less salt

Based on 165 responses to this part of the question, 76% of LHETs indicated that they taught choosing and preparing foods with less salt as part of a required health education course.

k. Eating more calcium-rich foods

Based on 165 responses to this part of the question, 84% of LHETs indicated that they taught eating more calcium-rich foods as part of a required health education course.

l. Keeping food safe to eat

Based on 165 responses to this part of the question, 75% of LHETs indicated that they taught keeping food safe to eat as part of a required health education course.

m. Preparing healthy meals and snacks

Based on 166 responses to this part of the question, 80% of LHETs indicated that they taught preparing healthy meals and snacks as part of a required health education course.

n. Risks of unhealthy weight control practices

Based on 164 responses to this part of the question, 92% of LHETs indicated that they taught risks of unhealthy weight control practices as part of a required health education course.

o. Accepting body size differences

Based on 166 responses to this part of the question, 84% of LHETs indicated that they taught accepting body size differences as part of a required health education course.

p. Eating disorders

Based on 166 responses to this part of the question, 88% of LHETs indicated that they taught eating disorders as part of a required health education course.

Question 10: During this school year, did teachers in this school teach each of the following physical activity topics in a required health education course for students in any of grades 6 through 12? (Mark yes or no for each topic.)

Topic

a. The physical, psychological, or social benefits of physical activity

Based on 165 responses to this part of the question, 94% of LHETs indicated that they taught the various benefits of physical activity as part of a required health education course.

b. Health-related fitness (i.e., cardiovascular endurance, muscular endurance, muscular strength, flexibility, and body composition)

Based on 165 responses to this part of the question, 90% of LHETs indicated that they taught health-related fitness as part of a required health education course.

c. Phases of a workout (i.e., warm-up, workout, and cool down)

Based on 166 responses to this part of the question, 80% of LHETs indicated that they taught phases of a workout as part of a required health education course.

d. How much physical activity is enough (i.e., determining frequency, intensity, time, and type of physical activity)

Based on 165 responses to this part of the question, 79% of LHETs indicated that they taught how much physical activity is enough as part of a required health education course.

e. Developing an individualized physical activity plan

Based on 166 responses to this part of the question, 65% of LHETs indicated that they taught developing an individualized physical activity plan as part of a required health education course.

f. Monitoring progress toward reaching goals in an individualized physical activity plan

Based on 167 responses to this part of the question, 57% of LHETs indicated that they taught monitoring progress toward reaching goals in an individualized physical activity plan as part of a required health education course.

g. Overcoming barriers to physical activity

Based on 166 responses to this part of the question, 65% of LHETs indicated that they taught overcoming barriers to physical activity as part of a required health education course.

h. Decreasing sedentary activities such as television watching

Based on 166 responses to this part of the question, 79% of LHETs indicated that they taught decreasing sedentary activities as part of a required health education course.

i. Opportunities for physical activity in the community

Based on 165 responses to this part of the question, 70% of LHETs indicated that they taught about opportunities for physical activity in the community as part of a required health education course.

j. Preventing injury during physical activity

Based on 165 responses to this part of the question, 80% of LHETs indicated that they taught preventing injury during physical activity as part of a required health education course.

k. Weather-related safety (e.g., avoiding heat stroke, hypothermia, and sunburn while physically active)

Based on 163 responses to this part of the question, 80% of LHETs indicated that they taught weather-related safety as part of a required health education course.

l. Dangers of using performance-enhancing drugs, such as steroids

Based on 163 responses to this part of the question, 88% of LHETs indicated that they taught the dangers of using performance-enhancing drugs as part of a required health education course.

Tobacco Use Prevention and HIV Prevention

Question 11: During this school year, in which of the following grades was information on tobacco use prevention provided? (Mark yes, no, or not applicable for each grade.)

The percentages responding affirmatively to this question ranged from 74% in grade 12 to 88% in grade 9.

Question 12: Are required tobacco use prevention units or lessons taught in each of the following courses in this school? (Mark yes, no, or don't know for each course.)

Course

a. Science

Based on 233 responses to this part of the question, 41% of LHETs indicated that they taught tobacco use prevention units or lessons in science courses.

b. Home economics or family and consumer education

Based on 243 responses to this part of the question, 44% of LHETs indicated that they taught tobacco use prevention units or lessons in home economics or family/consumer education courses.

c. Physical education

Based on 243 responses to this part of the question, 30% of LHETs indicated that they taught tobacco use prevention units or lessons in physical education courses.

d. Family life education or life skills

Based on 242 responses to this part of the question, 48% of LHETs indicated that they taught tobacco use prevention units or lessons in family life education or life skills courses.

e. Special education

Based on 284 responses to this part of the question, 29% of LHETs indicated that they taught tobacco use prevention units or lessons in special education courses.

Question 13: Are required HIV prevention units or lessons taught in each of the following courses in this school? (Mark yes or no for each course.)

Course

a. Science

Based on 235 responses to this part of the question, 50% of LHETs indicated that they taught HIV prevention units or lessons in science courses.

b. Home economics or family and consumer education

Based on 242 responses to this part of the question, 47% of LHETs indicated that they taught HIV prevention units or lessons in home economics or family and consumer education courses.

c. Physical education

Based on 241 responses to this part of the question, 19% of LHETs indicated that they taught HIV prevention units or lessons in physical education courses.

d. Family life education or life skills

Based on 239 responses to this part of the question, 48% of LHETs indicated that they taught HIV prevention units or lessons in family life education or life skills courses.

e. Special education

Based on 230 responses to this part of the question, 27% of LHETs indicated that they taught HIV prevention units or lessons in special education courses.

Collaboration

Question 14: During this school year, have any health education staff worked with each of the following groups on health education activities? (Mark yes or no for each group.)

Group

a. Physical education staff

Based on 258 responses to this part of the question, 64% of LHETs indicated that they worked with physical education staff on health education activities.

b. School health services staff (e.g., nurses)

Based on 257 responses to this part of the question, 73% of LHETs indicated that they worked with school health services staff on health education activities.

c. School mental health or social services staff (e.g., psychologists, counselors)

Based on 253 responses to this part of the question, 48% of LHETs indicated that they worked with school mental health or social services staff on health education activities.

d. Food service staff

Based on 250 responses to this part of the question, 21% of LHETs indicated that they worked with food service staff on health education activities.

e. Community members

Based on 252 responses to this part of the question, 54% of LHETs indicated that they worked with community members on health education activities.

Question 15: During this school year, has this school done each of the following activities? (Mark yes or no for each activity.)

Activity

a. Provided families with information on the health education program

Based on 262 responses to this part of the question, 63% of LHETs indicated that they provided families with information on the health education program.

b. Met with a parent's organization such as the PTA to discuss the health education program

Based on 258 responses to this part of the question, 12% of LHETs indicated that they met with a parent's organization such as the PTA to discuss the health education program.

c. Invited family members to attend a health education class

Based on 258 responses to this part of the question, 29% of LHETs indicated that they invited family members to attend a health education class.

Staff Development

Question 16: During the past two years, did you receive staff development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following health education topics? (Mark yes or no for each topic.)

Topic

a. Accident or injury prevention

Based on 257 responses to this part of the question, 32% of LHETs indicated that they received staff development in the area of accident or injury prevention, during the past two years.

b. Alcohol or other drug use prevention

Based on 260 responses to this part of the question, 39% of LHETs indicated that they received staff development in the area of alcohol or other drug use prevention, during the past two years.

c. Consumer health

Based on 254 responses to this part of the question, 15% of LHETs indicated that they received staff development in the area of consumer health, during the past two years.

d. CPR (Cardiopulmonary resuscitation)

Based on 259 responses to this part of the question, 51% of LHETs indicated that they received staff development in the area of CPR (cardiopulmonary resuscitation), during the past two years.

e. Death and dying

Based on 256 responses to this part of the question, 11% of LHETs indicated that they received staff development in the area of death and dying, during the past two years.

f. Dental and oral health

Based on 254 responses to this part of the question, 9% of LHETs indicated that they received staff development in the area of dental and oral health, during the past two years.

g. Emotional and mental health

Based on 259 responses to this part of the question, 27% of LHETs indicated that they received staff development in the area of emotional and mental health, during the past two years.

h. Environmental health

Based on 255 responses to this part of the question, 16% of LHETs indicated that they received staff development in the area of environmental health, during the past two years.

i. First aid

Based on 256 responses to this part of the question, 37% of LHETs indicated that they received staff development in the area of first aid, during the past two years.

j. Growth and development

Based on 258 responses to this part of the question, 18% of LHETs indicated that they received staff development in the area of growth and development, during the past two years.

k. HIV (human immunodeficiency virus) prevention

Based on 256 responses to this part of the question, 39% of LHETs indicated that they received staff development in the area of HIV prevention, during the past two years.

l. Human sexuality

Based on 255 responses to this part of the question, 19% of LHETs indicated that they received staff development in the area of human sexuality, during the past two years.

m. Immunization and vaccinations

Based on 254 responses to this part of the question, 21% of LHETs indicated that they received staff development in the area of immunization and vaccinations, during the past two years.

n. Nutrition and dietary behavior

Based on 258 responses to this part of the question, 26% of LHETs indicated that they received staff development in the area of nutrition and dietary behavior, during the past two years.

o. Personal hygiene

Based on 255 responses to this part of the question, 10% of LHETs indicated that they received staff development in the area of personal hygiene, during the past two years.

p. Physical activity and fitness

Based on 257 responses to this part of the question, 31% of LHETs indicated that they received staff development in the area of physical activity and fitness, during the past two years.

q. Pregnancy prevention

Based on 257 responses to this part of the question, 19% of LHETs indicated that they received staff development in the area of pregnancy prevention, during the past two years.

r. STD (Sexually transmitted disease) prevention

Based on 257 responses to this part of the question, 25% of LHETs indicated that they received staff development in the area of STD prevention, during the past two years.

s. Suicide prevention

Based on 257 responses to this part of the question, 19% of LHETs indicated that they received staff development in the area of suicide prevention, during the past two years.

t. Sun safety or skin cancer prevention

Based on 256 responses to this part of the question, 10% of LHETs indicated that they received staff development in the area of sun safety or skin cancer prevention, during the past two years.

u. Tobacco use prevention

Based on 256 responses to this part of the question, 27% of LHETs indicated that they received staff development in the area of tobacco use prevention, during the past two years.

v. Violence prevention (such as bullying, fighting, and homicide)

Based on 260 responses to this part of the question, 40% of LHETs indicated that they received staff development in the area of violence prevention, during the past two years.

Question 17: Would you like to receive staff development on each of these health education topics? (Mark yes or no for each topic.)

Topic

a. Accident or injury prevention

Based on 249 responses to this part of the question, 35% of LHETs indicated that they would like to receive staff development in the area of accident or injury prevention.

b. Alcohol or other drug use prevention

Based on 252 responses to this part of the question, 60% of LHETs indicated that they would like to receive staff development in the area of alcohol or other drug use prevention.

c. Consumer health

Based on 249 responses to this part of the question, 45% of LHETs indicated that they would like to receive staff development in the area of consumer health.

d. CPR (Cardiopulmonary resuscitation)

Based on 250 responses to this part of the question, 55% of LHETs indicated that they would like to receive staff development in the area of CPR.

e. Death and dying

Based on 252 responses to this part of the question, 49% of LHETs indicated that they would like to receive staff development in the area of death and dying.

f. Dental and oral health

Based on 249 responses to this part of the question, 29% of LHETs indicated that they would like to receive staff development in the area of dental and oral health.

g. Emotional and mental health

Based on 250 responses to this part of the question, 56% of LHETs indicated that they would like to receive staff development in the area of emotional and mental health.

h. Environmental health

Based on 250 responses to this part of the question, 43% of LHETs indicated that they would like to receive staff development in the area of environmental health.

i. First aid

Based on 249 responses to this part of the question, 53% of LHETs indicated that they would like to receive staff development in the area of first aid.

j. Growth and development

Based on 248 responses to this part of the question, 41% of LHETs indicated that they would like to receive staff development in the area of growth and development.

k. HIV (human immunodeficiency virus) prevention

Based on 251 responses to this part of the question, 54% of LHETs indicated that they would like to receive staff development in the area of HIV prevention.

l. Human sexuality

Based on 250 responses to this part of the question, 50% of LHETs indicated that they would like to receive staff development in the area of human sexuality.

m. Immunization and vaccinations

Based on 250 responses to this part of the question, 36% of LHETs indicated that they would like to receive staff development in the area of immunization and vaccinations.

n. Nutrition and dietary behavior

Based on 249 responses to this part of the question, 52% of LHETs indicated that they would like to receive staff development in the area of nutrition and dietary behavior.

o. Personal hygiene

Based on 251 responses to this part of the question, 31% of LHETs indicated that they would like to receive staff development in the area of personal hygiene.

p. Physical activity and fitness

Based on 250 responses to this part of the question, 51% of LHETs indicated that they would like to receive staff development in the area of physical activity and fitness.

q. Pregnancy prevention

Based on 251 responses to this part of the question, 47% of LHETs indicated that they would like to receive staff development in the area of pregnancy prevention.

r. STD (sexually transmitted disease) prevention

Based on 252 responses to this part of the question, 55% of LHETs indicated that they would like to receive staff development in the area of STD prevention.

s. Suicide prevention

Based on 252 responses to this part of the question, 64% of LHETs indicated that they would like to receive staff development in the area of suicide prevention.

t. Sun safety or skin cancer prevention

Based on 250 responses to this part of the question, 44% of LHETs indicated that they would like to receive staff development in the area of sun safety or skin cancer prevention.

u. Tobacco use prevention

Based on 251 responses to this part of the question, 51% of LHETs indicated that they would like to receive staff development in the area of tobacco use prevention.

v. Violence prevention (such as bullying, fighting, and homicide)

Based on 253 responses to this part of the question, 68% of LHETs indicated that they would like to receive staff development in the area of violence prevention.

Question 18: During the past two years, did you receive staff development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following teaching methods? (Mark yes or no for each teaching method.)

Teaching method

a. Teaching students with physical or cognitive disabilities

Based on 258 responses to this part of the question, 46% of LHETs indicated that they received staff development on teaching students with physical or cognitive disabilities, during the past two years.

b. Teaching students of various cultural backgrounds

Based on 257 responses to this part of the question, 36% of LHETs indicated that they received staff development on teaching students of various cultural backgrounds, during the past two years.

c. Teaching students with limited English proficiency

Based on 257 responses to this part of the question, 19% of LHETs indicated that they received staff development on teaching students with limited English proficiency, during the past two years.

d. Using interactive teaching methods such as role plays or cooperative group activities

Based on 258 responses to this part of the question, 55% of LHETs indicated that they received staff development on using interactive teaching methods such as role plays or cooperative group activities, during the past two years.

e. Encouraging family or community involvement

Based on 258 responses to this part of the question, 40% of LHETs indicated that they received staff development on encouraging family or community involvement, during the past two years.

f. Teaching skills for behavior change

Based on 257 responses to this part of the question, 47% of LHETs indicated that they received staff development on teaching skills for behavior change, during the past two years.

Question 19: Would you like to receive staff development on each of these teaching methods? (Mark yes or no for each teaching method.)

Teaching method

a. Teaching students with physical or cognitive disabilities

Based on 254 responses to this part of the question, 50% of LHETs indicated that they would like to receive staff development on teaching students with physical or cognitive disabilities.

b. Teaching students of various cultural backgrounds

Based on 256 responses to this part of the question, 42% of LHETs indicated that they would like to receive staff development on teaching students of various cultural backgrounds.

c. Teaching students with limited English proficiency

Based on 253 responses to this part of the question, 38% of LHETs indicated that they would like to receive staff development on teaching students with limited English proficiency.

d. Using interactive teaching methods such as role plays or cooperative group activities

Based on 254 responses to this part of the question, 50% of LHETs indicated that they would like to receive staff development on using interactive teaching methods such as role plays or cooperative group activities.

e. Encouraging family or community involvement

Based on 257 responses to this part of the question, 55% of LHETs indicated that they would like to receive staff development on encouraging family or community involvement.

f. Teaching skills for behavior change

Based on 254 responses to this part of the question, 66% of LHETs indicated that they would like to receive staff development on teaching skills for behavior change.

Note that *the percentage who would like to receive staff development exceeded the percentage who received staff development during the past two years—in every area except interactive teaching methods*. The difference in these percentages was greatest in the areas "teaching students with limited English proficiency," "encouraging family or community involvement," and "teaching skills for behavior change"—with 15-20% more LHETs desiring such training than had reported receiving it (during the past two years). Apparently, these are areas in which health education teachers feel they need more training.

Professional Preparation

Question 20: What was the major emphasis of your professional preparation? (Mark one response.)

Of the 231 responding, the combination of health and physical education was the most selected major emphasis (29%), followed by home economics or family/consumer science (26%) and physical education (13%).

Question 21: Including this school year, how many years have you been teaching health education? (Mark one response.)

Of the 256 responding, 6% had taught one year, 26% two to five years, 15% six to nine years, 26% 10 to 14 years, and 27% had taught 15 years or more.

V. Discussion and Recommendations

The survey data indicate that health education is being taught in an integrated curriculum in Iowa schools. Health is integrated or taught in conjunction with other subjects and is also sometimes taught via programs or activities outside of a regular classroom. Most lead health education teachers had either (1) health education and physical education or (2) home economics or family/consumer science as the major emphasis of their professional preparation. Just less than 70% of lead health education teachers have taught health education for more than five years and a majority have taught health education for at least 10 years.

Discussion

In the discussion that follows, we consider three critical areas of health education: (1) HIV and other STDs; (2) violent juvenile crime; and (3) tobacco use.

1. HIV and Other STDs: Policy, Student Behavior, and Preventive Health Education

Sixty-five percent of principals responding indicated that their schools have adopted a written policy that protects the rights of students or staff with HIV infection or AIDS. This was a substantial increase over the percent who indicated they had adopted such a policy in the 2000 SHEP (49%).

According to the 1997 Iowa Youth Risk Behavior Survey including 1,521 high school students from across the state, 27% of 9th graders, 39% of 10th graders, 50% of 11th graders, and 58% of 12th graders indicated that they had engaged in sexual intercourse (Veale, 1998). (See Figure 2.) Slightly over one-fifth of them indicated that they had four or more sexual partners (in their life) by the 12th grade. These percentages were close to those reported for the nation as a whole (Centers for Disease Control and Prevention, August 14, 1998). In the 1997 Iowa study,[3] among students who said they had intercourse during the three months prior to taking the survey, only about 48% said they or their partner had used a condom to prevent sexually transmitted diseases (Veale, 1998). Nationally, female students in grade 12 were significantly less likely to report using a condom during last intercourse than were female students in grades 9 or 11 (Centers for Disease Control and Prevention, August 14, 1998).[4]

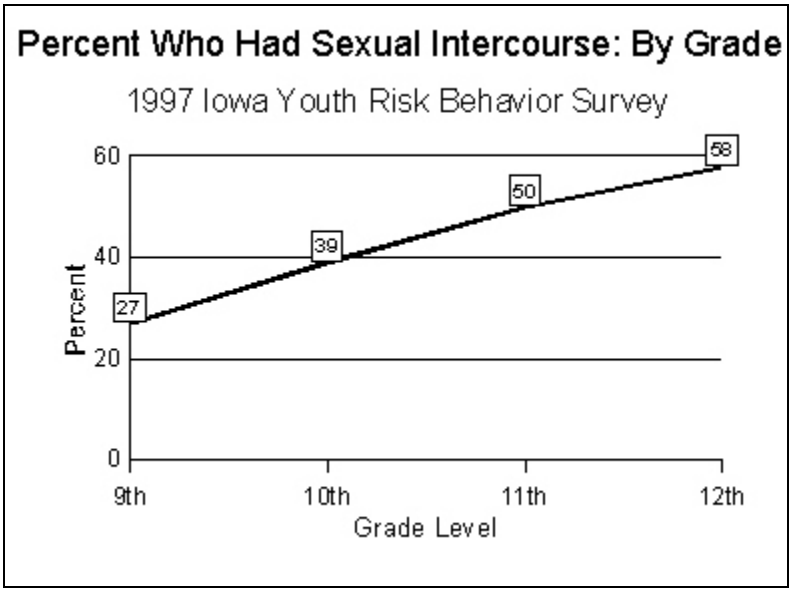

Figure 2: Percent indicating that they had engaged in sexual intercourse, by grade (Veale, 1998).

[3] This was the most recent YRBS in Iowa that provided weighted results, i.e., generalizable to all senior high school students in the state. The 2003 YRBS is currently being conducted.

[4] In Iowa, the percentage of all students who reported using a condom during last sexual intercourse was lower for grade 12 than for grades 10 or 11, but not significantly lower. (There were insufficient data in grade 9 for comparisons.)

Engaging in sexual intercourse, especially if protection is not used, puts students at risk of being infected with HIV and other STDs. *Yet, during their senior year in high school—when reported incidence of sexual intercourse was highest and reported condom use was lowest—only 32% of students received required health education (compared with 69% in grade 7 and 65% in grade 9).*

Most lead health education teachers in Iowa (98%) tried to increase student knowledge of HIV in required health education courses. Specifically, 97% taught abstinence as the most effective way to avoid HIV infection and 76% taught condom efficacy, but only 44% taught how to correctly use a condom (56% among senior high health education teachers)—as part of required health education.

2. Violent Juvenile Crime and Violence Prevention Activities

There is evidence that violent juvenile crime and delinquency are increasing in Iowa. For example, the number of delinquency petitions filed increased from 4,975 in 1992 to 6,610 in 2001 (Jerry Beatty, Judicial Branch, State of Iowa, personal communication, February 7, 2003). It is projected that the number for 2002 will increase to around 7,000 (ibid.). Teenage gang activity and gang-related crime have also increased in Iowa since the late 1980s. These are *health problems*, as well as social problems.

The challenges to those working in education, health care, juvenile justice, and human services are to (1) develop effective methods for reducing or controlling this problem and (2) ensure the provision of care for its victims. There is evidence from this profile that at least the first of these challenges is being met in the schools in Iowa. Seventy-nine percent of lead health education teachers in Iowa reported that they attempted to improve student knowledge in the area of violence prevention. Moreover, the skill of nonviolent conflict resolution was taught in 78% of schools in Iowa in 2002. Finally, there is evidence that many schools in Iowa have put security measures in place, such as requiring visitors to report to the main office or reception area, using staff or adult volunteers to monitor halls, and maintaining a "closed campus."

3. Tobacco Use Policy and Prevention Education

According to the Iowa Department of Education *Iowa Youth Survey*, self-reported cigarette smoking (two or more times per week) increased among Iowa youth from 1981, nearly doubling for students in grades 6, 8, 10, and 12 to 13% overall in 1996 (Governor's Alliance on Substance Abuse, 1997). At the high school level, 37.5% reported smoking cigarettes at least once in the month prior to the 1997 YRBS, while 12.8% reported using smokeless tobacco during this same period (Veale, 1998).

There is evidence from this profile that schools are making an effort to control, reduce, and prevent tobacco use. It was estimated that nearly all (99%) of principals in secondary schools in Iowa have adopted a policy prohibiting cigarette smoking by students. In most cases, this applied to all school buildings, school grounds, school buses, and school events. The most common actions taken when students are caught smoking cigarettes are to (1) refer the student to a school administrator and (2) inform the student's parent(s) or guardian(s) about her/his smoking. Policy specifically prohibiting students from using smokeless tobacco, cigars, and/or pipes was also reported by more than 90% of the principals. Most principals (over 90%) reported that tobacco advertising is prohibited in their schools, as is the wearing of tobacco name-brand apparel and the carrying of tobacco name-brand merchandise. Finally, 46% of principals indicated that their school had posted signs marking a tobacco-free school zone (up from 28% in the 2000 SHEP).

In terms of education, it was estimated that 98% of lead health education teachers in Iowa tried to increase student knowledge in the area of tobacco use prevention. Moreover, more than 90% of these teachers indicated that the following specific tobacco use prevention topics were taught in required health education courses in their schools: short- and long-term consequences of cigarette smoking and use of smokeless tobacco, benefits of not using cigarettes or smokeless to-

bacco, addictive effects of nicotine, number of young people using tobacco, number of deaths and illnesses related to tobacco use, the influence of the media on tobacco use, how to say no to tobacco use, and the effects of second-hand smoke. Fifty-one percent of health education teachers indicated they would like to receive training in tobacco use prevention; only 27% said they had received such training in the past two years.

Recommendations Concerning School Health Policy and Health Education Programs

1. *Encourage required health education courses, including HIV prevention training or reinforcement of earlier training, for juniors and seniors in high school.* Required health education courses should be delivered to more juniors and seniors, who are most at-risk of HIV infection because of their sexual activity. This should include skills for prevention of HIV and other STDs (e.g., correct use of condoms) as well as knowledge of HIV prevention (e.g., condom efficacy).

2. *Encourage the cooperation and collaboration among the components of the support system for the delivery of health education to students in Iowa schools.* Components of this system include local entities such as the school administration, parents, adult volunteers (e.g., mentors), community-based agencies, and the business community. Other components might include the Area Education Agency and state and federal government agencies, such as the HIV/AIDS Education Project in Iowa and the CDC. Federal- or state-funded research grants could be made available on a competitive basis for the development of programs to facilitate or enhance such local cooperation and collaboration. An example of where this is needed is the development of health advisory councils. Only 39% of schools in Iowa in 2002 had an active health education advisory council or similar committee, according to school principals. Another example of cooperation and collaboration is in the use of peer educators, reported by 51% of the lead health education teachers in Iowa in 2002. Moreover, 95% percent reported the teaching of refusal skills for resisting negative peer pressure. Programs should capitalize on the fact that kids talk to kids and utilize *positive* peer pressure to change their behavior. Community collaboration is a key to making such programs work. (See, e.g., "Peer Education ... a Little Help from Your Friends" by Jan Lunquist (Henderson & Champlin, with Evashwick, 1998).)

3. *Use violence prevention training (for students and teachers) more extensively to counter increases in violent juvenile crime and delinquency.* In particular, more emphasis should be given to teaching violence prevention *skills* to increase healthy behaviors among our youth. These include, *inter alia*, the development of de-escalation, mediation, and conflict resolution skills through role-playing, as well as a planned process for whole school discipline and safety (Dr. Lee Halverson, Consultant at Heartland Area Education Agency, personal communication, November 29, 1995). This may need to begin at the elementary level. An example of such a program at this level is the Woodbury Drug and Violence Prevention Program in Marshalltown, which includes a small group component for asset development (focusing on anger control, character education, empathy, social skill rehearsal, and leadership), classroom integration for asset development, community service learning, and neighborhood cooperation/enhancement (Veale, 2002a). This collaborative program, now in its seventh year, was cited by the Iowa Department of Public Health for "best prevention practices" in 1998.

Feedback and Recommendations Concerning the School Health Education Profile

For the most part, the comments from educators responding to the survey were positive, constructive, and informative. For example, one principal suggested that questions 19 (regarding tobacco prevention policy) and 35 (regarding purchasing snack foods/beverages) of their survey should have indicated whether they referred to "at school, off-campus, or both." A lead

health education teacher pointed out that because of the limitation (in many of the questions) to *required* health education courses, many items taught for human growth and development in the 7th and 8th grade science curriculums, physical education, and family and consumer science courses in his/her school could not be shown as having been taught.

One teacher stated: "Society needs to realize how important health education is. To be at (one's) best, a person has to be at their best physically, socially, and mentally ... Iowa needs to require more health education." There was also considerable interest expressed in staff development workshops, health-related materials, etc. One teacher suggested that more is needed along these lines, as well as in the dissemination of the results of the survey. Regarding the latter, we are planning to post these reports in a standard, accessible format on the Iowa Department of Education Web page. (As in the past, hard copies will be available upon request and administrative summaries will be sent to each school.) Another teacher suggested that the spring was not a good time to be filling out surveys. We hope to begin this process much earlier in the school year in the next SHEP (in 2004), so principals and teachers can have more time to complete these surveys.

Some administrators and teachers report that they are being inundated with surveys. Length of the survey is another factor that can affect participation. Regarding the 2002 SHEP for teachers, although it appears to contain just 21 questions, when the multiple parts comprising many of the questions are taken into consideration the survey actually contains nearly 200 items! Instead of being shortened, as we had recommended, it was actually *lengthened* over that of the 2000 SHEP. Moreover, the 2002 survey for principals increased from 23 questions to 41 (and four pages to six). Some of these additions were important (e.g., questions regarding asthma management); others may be less important (e.g., question regarding policy on the availability of fruits and vegetables in school).[5] These are not surveys that can be completed in five or ten minutes.

Administrators and teachers are experiencing greater educational challenges and are being asked to take on additional responsibilities in the intellectual, social/behavioral, and physical development of our youth—often with very limited resources. In light of this fact, we recommend that both surveys be shortened, utilizing response data as well as expert judgement in this process. In addition, it may be possible to combine this survey with others that are conducted periodically by the Departments of Education or Health. The percentages for the questions in the LHET survey have remained fairly stable in the past three administrations of the SHEP. In light of this fact, the teacher survey could be conducted every four years (every other two-year period). Any of these actions should help to secure the continued excellent cooperation of principals and lead health education teachers in providing important information regarding the health education of our youth.

[5] One of the principals commented: "In reference to question 32 (regarding policy on availability of fruits and vegetables in school), we do not need a new policy for every issue that an individual or group feels is important. Common sense must rule in most cases. Policies can sometimes *diminish* the ability to treat issues fairly and equitably" (emphasis added).

Acknowledgments

The author would like to thank Sara Peterson of the Iowa Department of Education (HIV/AIDS Education Project) for input and direction on this project and the following Iowa Department of Education personnel: Haila Huffman for clerical support, Xiaoping Wang for providing updated lists of school data, and Gary McCoy for producing labels for the survey mailings. I would also like to thank Westat, Inc. for supplying materials, including *PCSchool*, a computer program for generating the sample of schools, the statistical summaries of the data from the two questionnaires, and, in particular, Westat representatives Laura Alvarez-Rojas, Emily Grim, Mary Nixon and Barbara Queen for administrative and technical support. In addition, thanks go to Jennifer Williams for assistance in checking the surveys and preparing them for processing. Finally, I would like to thank the principals and lead health education teachers who participated in this survey, as well as the superintendents in their school districts for their support.

References

Centers for Disease Control and Prevention (August 14, 1998). Youth risk behavior surveillance—United States, 1997. In: *CDC surveillance summaries,* MMWR 1998; 47 (No. SS-3): 1-89.

Centers for Disease Control and Prevention (2002). *2002 School Health Education Profile Report: Iowa Department of Education*. Available through the HIV/AIDS Education Project, Iowa Department of Education, Des Moines, IA.

Cochran, W. (1963). *Sampling techniques* (2nd Ed.). New York: John Wiley & Sons, Inc.

Henderson, A. & Champlin, S., with Evashwick, W. (1998). *Promoting teen health: Linking schools, health organizations, and community*. Thousand Oaks, CA: Sage Publications.

Governor's Alliance on Substance Abuse (1997). Pulse check of substance abuse in Iowa. Governor's Alliance on Substance Abuse. Des Moines, IA.

Veale, J. (1994). *HIV Policy Evaluation for the HIV/AIDS Education Project*. Prepared for the Iowa Department of Education, with assistance from Dale I. Foreman. Des Moines, IA.

Veale, J. (1998). *1997 Iowa Youth Risk Behavior Survey*. Prepared for the Iowa Department of Education. Des Moines, IA.

Veale, J. (2000). *Iowa HIV training and education needs assessment: 1999-2000 survey for middle and high schools.* Prepared for the Iowa Department of Education, Bureau of Instructional Services. Des Moines, IA.

Veale, J. (2001a). *2000 Iowa School Health Education Profile*. Prepared for the Iowa Department of Education. Des Moines, IA.

Veale, J. (2001b). *Iowa HIV training and education needs assessment: 2000-01 survey for elementary schools.* Prepared for the Iowa Department of Education, Bureau of Instructional Services. Des Moines, IA.

Veale, J. (2002a). *2001-02 Woodbury Drug and Violence Prevention Program: Summary of results on outcomes measures*. Prepared for the Substance Abuse Treatment Unit of Central Iowa (SATUCI) and the Iowa Department of Public Health. Des Moines, IA.

Veale, J. (2002b). *Iowa HIV training and education needs assessment: 2002 summary report for secondary and elementary schools.* Prepared for the Iowa Department of Education, Bureau of Instructional Services. Des Moines, IA.

APPENDIX

The School Principal and Lead Health Education Teacher Questionnaires for the 2002 School Health Education Profile